

Exhibit G: Critical Incident Report Form

INCIDENT REPORT FORM

Please direct any questions to Steve Cazel at (360) 725-3706 or steve.cazel@dshs.wa.gov

Date Reported to the DBHR:	Date of Incident:	Time of Incident: (24 hour)	Location of incident:		
Reporting Site: RSN Provider Agency:		Name of Reporter:	Phone/Email: (/		
Brief description of the incident:					
<input type="checkbox"/> UNSUBSTANTIATED	<input type="checkbox"/> SUBSTANTIATED	<input type="checkbox"/> UNDER INVESTIGATION/UNDETERMINED			
<input type="checkbox"/> POTENTIAL FOR MEDIA COVERAGE?		<input type="checkbox"/> PROPERTY DAMAGE?			
TYPE OF INCIDENT					
<i>Instructions: Please click on the appropriate category for drop down menu where indicated by an asterisk</i>					
*ALLEGATIONS / DEATHS *INJURY / ESCAPES		*DISTURBANCE / CRIME			
PATIENT(1) INFORMATION		PATIENT(2) INFORMATION			
Patient Identifier:	Name: Last, First	Patient Identifier:	Name: Last, First		
PATIENT(3) INFORMATION		PATIENT(4) INFORMATION			
Patient Identifier:	Name: Last, First	Patient Identifier:	Name: Last, First		
STAFF (1) INFORMATION		STAFF (2) INFORMATION		STAFF (3) INFORMATION	
Name: Last, First		Name: Last, First		Name: Last, First	
VISITOR/OTHER INFORMATION					
Name: Last, First		Relationship:		Other Pertinent Information Related to the Visitor:	
OTHER AGENCY/FACILITIES NOTIFIED/INVOLVED					
<input type="checkbox"/> Law enforcement notified		<input type="checkbox"/> DSHS Communications notified		<input type="checkbox"/> Media has contacted Agency	
<input type="checkbox"/> Family notified		<input type="checkbox"/> Medicaid Control Fraud Unit		<input type="checkbox"/> None	
<input type="checkbox"/> APS notified		<input type="checkbox"/> Department of Health		<input type="checkbox"/> Other:	
<input type="checkbox"/> CPS notified		<input type="checkbox"/> DSHS Notified		Date of referral:	
FOLLOW-UP/CORRECTIVE ACTION INFORMATION				<input type="checkbox"/> THIS INCIDENT DOES NOT REQUIRE FOLLOW-UP	
Follow-up Date:		Action taken:			
Follow-up Date:		Action taken:			
Corrective Action Plan? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A		Describe CAP briefly:			
Case closed? <input type="checkbox"/> YES <input type="checkbox"/> NO		Date closed:		Incident Manager Comments:	